Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 728-3670

AUTHORIZATION TO RELEASE INFORMATION

TO: Dr. Terry Swartz
8180 Corporate Pk Dr.
Suite 104
Cincinnati, OH 45242

RE: State of Ohio v. Lee E. Moore

DATE: 11/17/99

You are hereby authorized to release to the Office of the Ohio Public Defender all records or other documents currently in your possession. Their representative may examine and make copies of all of my medical, psychological, hospital, police, and employment records, or any other records he/she may deem necessary in his/her work on my behalf. You are authorized to discuss these records and any other matters concerning me with said representative and are asked to assist him/her on the current investigation.

This authorization includes release of information concerning background, testing, and treatment of drug and alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV).

Lee E. Moore
Client's Signature

WITNESS:
Jessica M Lowe

Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 644-9972

DAVID H. BODIKER
State Public Defender

Date Rec'd _____

1st Follow-up _____

2nd Follow-up _____

November 17, 1999

Dr. Terry Swartz
8180 Corporate Park Dr.
Suite #104
Cincinnati, Ohio 45242

Re: State of Ohio v. Lee E. Moore

Dear Sir:

Please be advised that the Ohio Public Defender is representing **Lee E. Moore** in the above referenced matter. The information requested herein is necessary for a detailed social history to be completed on his behalf.

In our efforts to properly represent **Mr. Moore** we are requesting that you provide us with any and all ***psychiatric records*** regarding **Mr. Moore**. These records should include, but are not limited to:

Psychiatric

- date(s) of evaluation;
- tests administered;
- interview reports;
- case notes;
- collateral information used, i.e., medical reports, school records, interviews with friends and/or family, etc.;
- diagnosis;
- prognosis;
- recommendation for treatment and/or placement.

009034(A)

To assist you in locating these records, **Mr. Moore's** birthdate is **10/19/74** and his social security number is [redacted]. His parents are **Lee and Georgia Moore**.

It is our understanding that Mr. Moore attended 4 – 6 counseling sessions with you during 1993. His mother was employed at General Motors at the time and is not certain what insurance covered the services.

In addition to our records request stated above please indicate the name of your agency's custodian of records, as it may be necessary to have the authenticity of the documents verified. Please forward this information to Ohio Public Defender, Attn: Jessica H. Love on or before November 27, 1999.

An authorization for release of all such records is enclosed for your files.

Sincerely,

Jessica H. Love
Mitigation Specialist

JL/cw

Enclosure

#101631v1

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

WALTER S. SMITSON, PH.D.
Executive Director

NANCY SCHMIDTGOESSLING, PH.D.
Director

WILLIAM WALTERS, PH.D.
Assistant Director

GAIL HELLMANN, M.D.
Medical Director

MARILYN GEEDING, L.I.S.W.
Treatment Coordinator

SHERRY SANDERS, L.P.C.C.
Forensic Liaison

CHARLOTTE E. HOLLAND
Office Manager

September 1, 1994

Bethesda Hospital
Attn: Dr. Schwartz
619 Oak Street
Cincinnati, Ohio 45206

RE: Lee Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell, B.S.
Psychology Trainee

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Dr Schwartz @ Bethesda 1991 or 92

ADDRESS 619 Oak St., 45206

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

(✓) Discharge Summary
(✓) Face Sheet with Final Diagnosis
(✓) Complications & Operative Procedures
(✓) History and Physical
(✓) Consultative Report(s)
( ) Inpatient (✓) Outpatient

(✓) Reports of Tests or X-rays
(✓) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: ?
( ) Other Medications
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore X Lee E. Moore (Signature of Client)

Date of Birth 10-19-74

Social Security No. [redacted] 9-1-94 (Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____ (Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

009037

LAW OFFICES

CHUCK R. STIDHAM
CHRISTOPHER J. BERNARD

SAND, STIDHAM AND BERNARD
317 W. BENSON STREET
READING, OHIO 45215
(513) 761-4929
FAX (513) 761-3573

*ROBERT G. SAND
(1932-1990)
*HARRY A. SAND
(1922-1987)

July 22, 1994

Terry R. Schwartz, M.D.
Bethesda Oak Hospital
629 Oak
Cincinnati, Ohio 45206

RE: Lee Edward Moore
D.O.B. - 10-19-74

Gentlemen:

This office is handling the Mitigation Phase of the case pending in the Hamilton County Court of Common Pleas wherein Lee Edward Moore is facing a possible death sentence.

In an effort to present factors in mitigation to prevent the execution of Mr. Moore, I am attempting to compile as much of a personal history and background as possible. To this end, I have enclosed herein an Authorization and Release Form which permits you to release information concerning Mr. Moore's education to me. I would appreciate if you would have this information to me as quickly as possible.

I specifically need information concerning his treatment and condition.

I would appreciate if you would provide this information to me as quickly as possible as his Trial is scheduled to commence in the Hamilton County Court of Common Pleas in late August, 1994.

Very truly yours,

Chuck R. Stidham
Attorney at Law

CRS/tas

Encl.

Preferred Health Care Ltd.
[illegible], Suite 1000
[illegible] MI 48034

Preferred Health Care

3/26/92

TERRY SCHWARTZ
BETHESDA DOCTORS BLDG
629 OAK ST,STE 600
CINCINNATI, OH 45206

Dear TERRY SCHWARTZ: Re: LEE MOORE

Preferred Health Care Ltd. (PHC), the Central Review Organization (CRO) for General Motors Corporation, determines the medical necessity of mental and health and substance abuse treatment and authorizes the payment of benefits for enrollees of General Motors/Connecticut General Health Benefit Plan, known as CARELINE.

This letter is in regard to the treatment of the above named patient. Based on a review of the information provided by the treating physician and/or other members of the treatment team, PHC has determined that treatment for the period from 3/30/92 to 5/01/92 meets PHC's national professional criteria for medical necessity.

06 UNITS FROM 03/30/92 THRU 05/01/92

Additional treatment beyond these dates, as well as specific services such as psychological testing, must be reviewed in advance before PHC will recommend payment. Therefore you must call 1-800-235-2302 for consideration of further authorization.

Please note that this letter does not guarantee payment for services. In addition to the Predetermination Requirement for reimbursement, payment depends on a number of factors including the enrollee's eligibility for coverage under the benefit plan, benefit plan limitations and the coordination of benefits with other plans. If you have questions about claims, please contact Connecticut General at 1-800-523-4626 (nationwide), 313-354-8330 (Detroit area).

Please call 1-800-235-2302 between the hours of 9:00 a.m. and 8:00 p.m., Eastern Standard Time if you have any questions.

Sincerely,

JUNE TRIPLETT
Case Management Unit

[redacted] 2-B-0

cc:

ThePrudential
The Prudential Insurance Company of America
P.O. Box 2850, Cincinnati, OH 45201-2850
513-621-2884

From: Terry A Schwartz Psy.D.

Date: 02/24/92
Patient's Name: Lee Moore
ID#: [redacted]

MENTAL HEALTH EVALUATION REPORT

Following the initial 2 evaluation visits, please submit the following information:

1. Multiaxial Diagnosis: 312.80 Conduct Disorder, low grades, caught with brass knuckles, lies, stays out late, sexually active stubborn, skipping school

2. Target symptoms/signs/problems: anti-social behaviors, won't follow any rules at home or at school
* No background or history available or given.

3. Specific goals for each target problem: Try to set limits and create some responsiveness to rules

4. Method of treating each problem: Behavioral, Cognitive behavioral, unsuccessful.

5. Time frame for acheiving each goal: 3 months; Termination due to failure to reach him. Tx should not open up and discuss anything "Pulling Teeth"

6. Who is Provider treating each problem: [signature] PsyD

7. Frequency of visits with each Provider: Total sessions 02/24, 03/02, 03/11 03/15, 02/25/92

8. Criteria for discharge from treatment: Client (Lee) was unresponsive he would not say much as utter a word, answered questions with "Yeah" or no, would not elaborate, Terminated due to failure to reach him in any constructive ways.

Mail To: PruCare of Cincinnati
P.O. Box 2850
Cincinnati, Ohio 45201

— OVER —

Dear Mr Chuck Stidham

I'm sorry I do not have anything more to offer. I have no other notes or records other than one sentence documentations on Leo's unwillingness to talk or open up. I cannot make any more statements on background or history because I have none.

Respectfully

I, LEE EDWARD MOORE, 1101 Clearbrook Drive, Cincinnati, Ohio 45229, hereby authorize you to release information concerning my health records to Chuck R. Stidham, Esq., Mitigation Specialists of Southwest Ohio, 317 W. Benson Street, Cincinnati, Ohio 45215.

Lee Edward Moore

STATE OF OHIO)
) SS:
COUNTY OF HAMILTON)

Sworn to before me and subscribed in my presence by Lee Edward Moore on this 13 day of [illegible], 1994.

Notary Public

CHUCK R. STIDHAM, Attorney at Law
NOTARY PUBLIC - STATE OF OHIO
My Commission has no expiration
date. Section 147.03 O.R.C.

INSTRUCTIONS:
The top portion of the claim form is to be completed the subscriber. The bottom portion is to be completed the physician or supplier.

PATIENT AND SUBSCRIBER INFORMATION (TO BE COMPLETED BY SUBSCRIBER)

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Moore, Lee
2. PATIENT'S DATE OF BIRTH: 10 | 19 | 74
3. PATIENT I. D. NO.: [redacted]
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 1280 Meredith Dr Cincinnati Ohio 45231
TELEPHONE NO. 513-522 9203
5. PATIENT'S SEX: MALE ☐ FEMALE ☐
6. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITI): Georgia Moore
7. PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF ☐ SPOUSE ☐ CHILD ☑ OTHER ☐
8. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE): Same
TELEPHONE NO.
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES ☐ NO ☑
B. ACCIDENT: NO ☐ AUTO ☐ OTHER ☑
11. SUBSCRIBER'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP C): G.M. Connecticut gener.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
SIGNED x Georgia L. Moore DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGN PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
x Georgia L. Moore
SIGNED SUBSCRIBER OR AUTHORIZED PERSON DATE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE\SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBI AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN OR SUPPLIER)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED
19. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFI
YES ☐ NO ☐ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
312.90
PRIOR AUTHORIZATIC

PLACE OF SERVICE CODE (1 - INPATIENT HOSP. 2 - OUTPATIENT HOSP. 3 - DOCTOR'S OFFICE 4 - HOME VISIT 5 - SURG. CTR/DR'S OFFICE 6 - NURSING HOME 7 - INDEPEND. LAB 8 - OTHER LOCATION 9 - SURGICAL CENTER)	22. A DATE OF SERVICE FROM TO	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES
	03/02/92	0	90844	Psychotherapy	312.90	85 00
	03/11/92	"	"	"	4	85 00
	03/18/92	"	"	"	"	85 00
	03/25/92	"	"	"	"	85 00

23. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE
Terry R. Schwartz Psy.D.
DATE:
24. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY)
YES ☑ NO ☐
25. TOTAL CHARGE 340
26. AMOUNT PAID
27. BALANCE 340
28. YOUR SOCIAL SECURITY NO. [redacted]
29. PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS ZIP CODE AND TELEPHONE NO. 513-281 4.
Terry R. Schwartz, Psy.D.
Bethesda Oak Professional Center
629 Oak Street, Suite 600
Cincinnati, Ohio 45206
ID # OR LICENSE # 3528
30. YOUR PATIENT'S ACCOUNT NO.
31. YOUR EMPLOYER I.D. NO.

CC-CL

009043

Preferred Health Care Ltd.
[illegible] Suite 1000
[illegible], MI 48033

Preferred Health Care

2/26/92

TERRY SCHWARTZ
9462 HUNTERS CREEK
CINCINATTI, OH 45242

Dear TERRY SCHWARTZ: Re: LEE MOORE

Preferred Health Care Ltd. (PHC), the Central Review Organization (CRO) for General Motors Corporation, determines the medical necessity of mental and health and substance abuse treatment and authorizes the payment of benefits for enrollees of General Motors/Connecticut General Health Benefit Plan, known as CARELINE.

This letter is in regard to the treatment of the above named patient. Based on a review of the information provided by the treating physician and/or other members of the treatment team, PHC has determined that treatment for the period from 2/24/92 to 3/30/92 meets PHC's national professional criteria for medical necessity.

06 UNITS FROM 02/24/92 THRU 03/30/92

Additional treatment beyond these dates, as well as specific services such as psychological testing, must be reviewed in advance before PHC will recommend payment. Therefore you must call 1-800-235-2302 for consideration of further authorization.

Please note that this letter does not guarantee payment for services. In addition to the Predetermination Requirement for reimbursement, payment depends on a number of factors including the enrollee's eligibility for coverage under the benefit plan, benefit plan limitations and the coordination of benefits with other plans. If you have questions about claims, please contact Connecticut General at 1-800-523-4626 (nationwide), 313-354-8330 (Detroit area).

Please call 1-800-235-2302 between the hours of 9:00 a.m. and 8:00 p.m., Eastern Standard Time if you have any questions.

Sincerely,

TERRA SIMMONS/CSR
Case Management Unit

S.S. #: [redacted] 2-B-0

cc: GEORGIA MOORE

INSTRUCTIONS:
The top portion of the claim form is to be completed the subscriber. The bottom portion is to be completed the physician or supplier.

PATIENT AND SUBSCRIBER INFORMATION (TO BE COMPLETED BY SUBSCRIBER)

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Moore, Lee
2. PATIENT'S DATE OF BIRTH: 10 | 19 | 74
3. PATIENT I.D. NO.: [redacted]
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 1280 Meredith Dr Cinti Ohio 45231
TELEPHONE NO. 513-522 9203
5. PATIENT'S SEX: MALE ☐ FEMALE ☐
6. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Georgia Moore
7. PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF ☐ SPOUSE ☐ CHILD ☑ OTHER ☐
8. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE): Same
TELEPHONE NO.
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES ☐ NO ☑
B. ACCIDENT: NO ☐ AUTO ☐ OTHER ☑
11. SUBSCRIBER'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP C.: G.M. Connecticut Gener.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
SIGNED x Georgia L. Moore DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGN PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
x Georgia L. Moore
SIGNED SUBSCRIBER OR AUTHORIZED PERSON DATE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE\SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBM AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN OR SUPPLIER)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED
19. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFF
YES ☐ NO ☐ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE: 312.90
PRIOR AUTHORIZATIO

PLACE OF SERVICE CODE	22. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES
1 - INPATIENT HOSP. 2 - OUTPATIENT HOSP. 3 - DOCTOR'S OFFICE 4 - HOME VISIT 5 - SURG. CTR/DR'S OFFICE 6 - NURSING HOME 7 - INDEPEND. LAB 8 - OTHER LOCATION 9 - SURGICAL CENTER	02/24/92		B	90844	[illegible]	312.90	85 00

23. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE.
Terry R. Schwartz Psy.D.
DATE:
24. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES ☑ NO ☐
25. TOTAL CHARGE 85.00
26. AMOUNT PAID
27. BALANCE D 85 00
28. YOUR SOCIAL SECURITY NO.: [redacted]
29. PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS ZIP CODE AND TELEPHONE NO. 513-281 46
Terry R. Schwartz, Psy.D.
Bethesda Oak Professional Center
629 Oak Street, Suite 600
Cincinnati, Ohio 45206
ID # OR LICENSE # 3528
30. YOUR PATIENT'S ACCOUNT NO.
31. YOUR EMPLOYER I.D. NO.

CC-CL

Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 752-5167

DAVID H. BODIKER
State Public Defender

FAX HEADER

CAUTION - CONFIDENTIAL

THIS DOCUMENT IS BEING TELECOPIED TO YOU AND MAY CONTAIN INFORMATION PROTECTED BY ATTORNEY-CLIENT OR WORK PRODUCT PRIVILEGES.

This document which follows is only intended for the person to whom it is addressed. If you are not the intended recipient or authorized agent, then this is notice to you that dissemination, distribution or copying of this document is prohibited. If this document is received in error, please call the sender at once and destroy the document.

DATE: 11-8-99

TO: Brenda Green - 946-2730

FROM: Jessica H. Love - 800-686-1573

TOTAL NUMBER OF PAGES BEING FAXED (INCLUDING HEADER): _____

CONFIRM FAX RECEIVED TO: _____

RE: Any & All Information on Lee Edward Moore

OPD/#10021<7qd01!>/11-95

Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 728-3670

AUTHORIZATION TO RELEASE INFORMATION

TO: Youth Center
2020 Auburn
Cincinnati, Oh
ATN: Brenda Green

RE: Lee E. Moore

DATE: 11/8/99

You are hereby authorized to release to the Office of the Ohio Public Defender all records or other documents currently in your possession. Their representative may examine and make copies of all of my medical, psychological, hospital, police, and employment records, or any other records he/she may deem necessary in his/her work on my behalf. You are authorized to discuss these records and any other matters concerning me with said representative and are asked to assist him/her on the current investigation.

This authorization includes release of information concerning background, testing, and treatment of drug and alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV).

Lee E. Moore
Client's Signature

WITNESS:
Jessica M. Love

Hamilton County
Juvenile Court
Youth Center

2020 Auburn Avenue
CINCINNATI, OHIO 45219-3097
(513) 946-2600

SYLVIA SIEVE HENDON, JUDGE
(513) 852-8707
(513) 852-3822 FAX

James C. Ray, Jr.
Court Administrator
(513) 852-8714
(513) 852-8899 Fax

THOMAS R. LIPPS, JUDGE
(513) 852-8712
(513) 852-8550 FAX

Robert J. Dugan
Superintendent
(513) 946-2644
(513) 946-2675 Fax

November 12, 1999

Jessica Love
Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215

Dear Ms. Love:

As a follow-up to our telephone conversations, according to computer records to which I have access personally, Lee Edward Moore (BD 10-19-74) was admitted and released from Detention on 8-12-92. As such, any medical records were destroyed according to Juvenile Court policy and no psychological reports were generated.

If I can be of further assistance or if you can provide me with other admission dates, please don't hesitate to call me at (513) 946-2636.

Sincerely,

Brenda L. Greene

Brenda L. Greene, R.N.
Certified Nurse Practitioner
Medical Department

Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 644-9972

DAVID H. BODIKER
State Public Defender

430240
M

November 24, 1999

Children's Hospital
3333 Burnet Avenue
Cincinnati, Ohio 45229

RECEIVED
NOV 2 ? 1999
BY:_____

Attention: Medical Records

Re: State of Ohio v. **Lee E. Moore**

Dear Sir/Madam:

Please be advised that the Ohio Public Defender is representing **Lee E. Moore** in the above referenced matter. The information requested herein is necessary for a detailed social history to be completed on his behalf.

In our efforts to properly represent **Mr. Moore** we are requesting that you provide us with any and all ***medical records*** regarding **Mr. Moore**. These records should include, but are not limited to:

MEDICAL

- admission and release dates;
- presenting problems, diagnoses, treatment plans
- and attending physicians' names'
- referrals, if applicable;
- prescriptions;
- testing and test outcomes including: X-rays,
- psychological evaluations, urine
- tests, blood tests, CAT scans, etc.

To assist you in locating these records, **Mr. Moore's** birthdate is **10/19/74** and his social security number is [redacted]. His parents are **Lee and Georgia Moore.**

Children's Hospital
November 24, 1999
Page Two

In addition to our records request stated above please indicate the name of your agency's custodian of records, as it may be necessary to have the authenticity of the documents verified. Please forward this information to Ohio Public Defender, Attn: Jessica H. Love on or before December 3, 1999.

An authorization for release of all such records is enclosed for your files.

Sincerely,

Jessica H. Love
Mitigation Specialist

JL/cw

Enclosure

#102097v1

SMART
CORPORATION Health Information Outsourcing Services

Dear Requestor:

The enclosed health information was provided to you by Smart Corporation's health information outsourcing service. We are under agreement with the medical facility to release authorized copies of medical records. Smart will continue to copy records that you request from this facility.

If you have any questions regarding the enclosed records, please contact Smart Corporation's area office listed below:

Smart Corporation
55 Union Street
3rd Floor
Boston, MA 02108
800-448-6278

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Children's Hospital Medical Center

Attention:

The following information is in accordance with Section 2317.422 of the revised Code of the Legislation of the State of Ohio, effective September 30, 1994.

I hereby certify that the attached data are true copies of the records requested on:

Patient Name: Moore, Lee

Medical Record Number: 430260

These copies were reproduced from the original records prepared in the usual course of business of the Medical Records Department of Children's Hospital Medical Center on this date: 12/17/99.

If you have questions about the enclosed records, please contact our Correspondence Coordinator, Danita Carter at (513)-636-8233.

Sincerely,

Donna Krach, ART

Donna Krach, ART
Assistant Director
Medical Record Department

Subscribed and sworn to, in my presence, this 17th day of December

SEAL

TAUNYA RENEE KESSLER
Notary Public, State of Ohio
My Commission Expires

Taunya Kessler

3333 Burnet Avenue
Cincinnati, Ohio 45229-3039

009052